UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA

ROMIE HARRIS, JR., AMY HARRIS, RUBY FRANCIS FOWLER, MARY LOIS GREEN, JAMES THOMAS, LULA THOMAS and JANIE BUFORD,	§	
Plaintiffs	§	
v.	§	CIVIL ACTION NO. 2:06-CV-00956
PACIFICARE LIFE AND HEALTH INSURANCE COMPANY, ROBERT D. BELL, ELIZABETH R. CLARK, WILLIE C. TILLIS, and Fictitious Defendants A through Z, those corporations, partnerships, LLC's, individuals or other entities who conduct contributed to the damages claimed herein whose names are not yet known to Plaintiffs but will be substituted by amendment when ascertained.	§	
Defendants	§	

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY'S RESPONSE TO PLAINTIFFS' NOTICE OF SUPPLEMENTAL AUTHORITY IN SUPPORT OF MOTION TO REMAND

COMES NOW PacifiCare Life and Health Insurance Company ("PacifiCare"), and files this Response to Plaintiffs' Notice of Supplemental Authority in Support of Motion to Remand, as follows:

1. On May 24, 2007, Plaintiffs filed a Notice of Supplemental Authority in Support of Motion to Remand (the "Notice"). The Notice directs the Court's attention to a Bulletin issued by Walter Bell, the Commissioner of Insurance for the State of Alabama, Department of Insurance (the "Bulletin"), on February 16, 2006. Plaintiffs mistakenly assume that the Bulletin's language means that CMS is "deflecting" claims regarding Medicare marketing to the Alabama Department of Insurance, thus concluding that "any licensed agent or entity engaging

in wrongful, deceptive or fraudulent marketing conduct related to Medicare sales in Alabama is subject to the laws and regulations of the State of Alabama." (Notice at ¶¶ 3-4). In essence, Plaintiffs contend that because CMS *allegedly* does not monitor or regulate the marketing practices of Medicare in Alabama, including the sale of Secure Horizons' Private Fee For Service (PFFS) plan at issue in this case, federal Medicare preemption does not apply to Plaintiffs' claims.

2. Plaintiffs' argument is specious for several reasons. First, the Bulletin issued by the Alabama Department of Insurance does not have the force or effect of law, nor does the agency have or even purport to have the authority to interpret federal law and its application.

3. Second, the Centers for Medicare & Medicaid Services ("CMS") has recently made very clear that it retains the authority to monitor, investigate, and resolve issues pertaining to the marketing of Medicare plans. Specifically, CMS recently reaffirmed the role of federal regulation in such marketing efforts. On May 25, 2007, the Director of the Center for Beneficiary Choices, a department of the CMS, issued a Memorandum to all Medicare Advantage ("MA") PFFS plans setting forth the federal expectations and requirements for proper marketing practices (hereafter, the "CMS Memorandum", attached hereto as "Exhibit A"). The purpose of the CMS Memorandum is to detail marketing processes and best practices with which all PFFS plan providers—including PacifiCare—must comply. (Exhibit A, ¶ 2). When read in conjunction with applicable federal statutes, regulations, and Medicare marketing and enrollment rules, it is clear that marketing practices by Medicare PFFS plans are controlled by federal law, which thus necessarily preempts state law claims related to marketing and enrollment practices.

4. In fact, as the the CMS Memorandum details, the marketing processes that may be used require prior authorization from and substantial involvement of CMS. For example, MA organizations offering PFFS plans must provide CMS Regional Managers with information on a

monthly basis regarding any planned PFFS marketing and sales events prior to such events taking place. (*Id.* at ¶ 3). All advertisements and enrollment materials related to PFFS plans must now include a specific CMS-created disclaimer, detailing how PFFS plans differ from Medicare Supplement plans. (*Id.* at ¶ 5). Moreover, CMS clearly mandates that MA organizations immediately discontinue the use of marketing materials or cease giving presentations which imply that PFFS plans function as a Medicare Supplement. Any revised marketing or advertising materials must be submitted to CMS for processing and certification. (*Id.* at ¶ 4). To emphasize the federal authority by which CMS intends to enforce such marketing practices and policies, the CMS Memorandum includes the following language:

> *CMS remains vigilant in protecting Medicare beneficiaries.* We will focus compliance oversight activities on ensuring the provision of information to beneficiaries accurately represents the access, network, and payment features of PFFS plans generally, and each organization's specific plan. *CMS has the authority to impose intermediate sanctions and penalties including the freezing of all marketing and enrollment, civil money penalties and other enforcement actions as described in Federal regulations at 42 C.F.R. §422 Subpart K and O, against organizations violating Medicare program requirements.* We are closely monitoring beneficiary complaints and other marketplace-based information to determine whether compliance and/or enforcement actions are warranted.

(*Id.* at ¶ 20) (emphasis added). Without a doubt, CMS has been and remains heavily involved in setting applicable legal standards, then monitoring, investigating, and controlling marketing activities by Medicare PFFS plans.

5. Plaintiffs' allegations in this lawsuit squarely fit into the marketing practices for which CMS sets the legal standards. Plaintiffs readily admit that their primary complaint in this suit relates to alleged wrongful and deceptive marketing practices by PacifiCare's agents in the sale of Secure Horizons, a PFFS plan. (Notice at ¶ 4). Prior regulations (cited in PacifiCare's Response to Plaintiffs' Motion to Remand and not repeated here) and the CMS Memorandum specifically indicate that CMS not only has authority to set the appropriate legal standard and govern marketing conduct, but that CMS has excercised that authority by requiring organizations

offering PFFS plans to comply with its standards and processes. (Exhibit A, ¶ 2). Under the clear terms of the CMS Memorandum, any argument by Plaintiffs that CMS is somehow "deflecting" the regulation of PFFS marketing practices to the states is erroneous.

6. Because Medicare generally provides for preemption of state law claims related to its terms, Plaintiffs' claims are preempted by federal law. The CMS Memorandum underscores the active federal regulation of Medicare PFFS plans' marketing activities, and thus the validity of PacifiCare's removal of this case to federal court pursuant to 28 U.S.C. §§ 1331 and 1444(b) on grounds that Plaintiffs' claims all arise under under the federal Medicare Act, 42 U.S.C. §1395w-21-w28, as amended by the Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA").

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the 8th day of June, 2007, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the following:

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and I hereby certify that I have mailed by U.S. Postal Service the document to the non CM/ECF participants:

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Of Counsel

EXHIBIT A

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

CENTER FOR BENEFICIARY CHOICES

DATE: May 25, 2007

TO: Medicare Advantage Private Fee-for-Service (PFFS) Plans

FROM: Abby L. Block
Director, Center for Beneficiary Choices (CBC)

SUBJECT: Ensuring Beneficiary Understanding of Private Fee-for-Service Plans, Actions and Best Practices

Private Fee-For-Service (PFFS) plans are a growing segment of the Medicare Advantage (MA) program. These plans differ from other MA products. As more PFFS plans become available, CMS began to work with beneficiaries, providers and MA organizations to provide education and information describing this plan option.

As described in the 2008 Call Letter, CMS is providing additional model documents and requiring new outreach processes to ensure beneficiaries and providers are informed about the distinctive features of Medicare PFFS plans. MA organizations offering PFFS plans are strongly encouraged to implement these new elements and practices as quickly as possible. Several of these must be implemented immediately as indicated in the discussion below. All PFFS organizations must have these processes in place prior to marketing CY 2008 PFFS plans.

PFFS Marketing Processes

1. Sales presentation schedules
MA organizations offering PFFS plans must provide their CMS Regional Office Plan Manager with listings of planned PFFS marketing and sales events, using the attached spreadsheet (refer to **Attachment 1**). Data for events conducted by both employed and contracted sales representatives is required. Beginning June 20, 2007, by the 20th of each month you must provide information for all events scheduled for the following month. The first report is due by June 20, 2007 and must list all events planned for July 2007. The Regional Office Plan Manager must be notified of updates to the schedule as appropriate. In addition, CMS encourages PFFS plans to maintain an up-to-date schedule of sales events on the plan's website. Each submitted spreadsheet must be accompanied by a signed and dated attestation from the organization's Medicare program vice president or director, attesting to

best knowledge, information and belief, that the information provided to CMS is accurate as of the date submitted.

2. Prohibition against implying PFFS plans function as Medicare supplements
MA organizations offering PFFS plans are prohibited from using any materials or making any presentations that imply PFFS plans function as Medicare supplement plans or use terms such as "Medicare Supplement replacement". MA organizations may not describe PFFS plans as plans that cover expenses that Original Medicare does not cover nor as plans that offer Medicare supplemental benefits. It would be permissible, however, for PFFS plans to clarify that the plan does not pay after Medicare pays its share, but rather, it pays instead of Medicare and the beneficiary pays any applicable cost-share or co-pay. Immediately discontinue use of any materials not meeting this requirement. Revised materials may be submitted through the File and Use Certification process.

3. PFFS marketing material disclaimer
MA organizations offering PFFS plans are required to prominently display the following disclaimer in all advertisements and enrollment related materials:

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital must agree to accept the plan's terms and conditions prior to providing healthcare services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may not provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at: [insert link to PFFS terms and conditions].

This language is also required in sales presentations in public venues and private meetings with beneficiaries. Any statement indicating that enrollees may see any provider must also include, the phrase ". . . who agrees to accept our terms and conditions of payment." CMS approval of this language prior to use is not required. Plans should begin using the disclaimer language immediately in sales presentations and as soon as possible in printed materials.

4. Beneficiary and provider leaflet
All MA organizations must provide enrollees with a complete description of plan rules, including detailed information on a provider's choice whether to accept plan terms and conditions of payment. A model document that beneficiaries may show their health care providers has been developed for this purpose (refer to **Attachment 2**). The model is a two-sided leaflet, with information for beneficiaries on one side and information for providers on the reverse.

The leaflet must be included in all enrollment kits that prospective enrollees receive. This leaflet must be available on your website for beneficiaries who enroll online. CMS will also post a model leaflet on the Medicare.gov website. It may be helpful to provide several copies to each beneficiary so that they can give copies to their health care providers. The leaflet must be implemented as quickly as possible and submitted to CMS using the File and Use Certification process prior to marketing CY 2008 PFFS plans.

5. Outbound education and verification calls

All MA organizations offering PFFS plans are required to conduct outbound education and verification calls to ensure beneficiaries requesting enrollment understand the plan rules. It is important for your sales staff to obtain from the beneficiary the verification phone number and provide a description of the enrollment verification process to the beneficiary during the application process. Your approved enrollment application form must accommodate this requirement.

Outbound calls mean that calls are made to the beneficiary after the sale has occurred. Calls cannot be made at the point of sale. You must ensure that the verification calls made to beneficiaries who request enrollment through sales agents are not made directly by those sales agents and also that the sales agents are not with the beneficiaries at the time of the verification call. You will be required to conduct these calls for all new enrollments except enrollments into employer or union sponsored PFFS plans or switches from one PFFS plan to another PFFS plan offered by the same MA organization. A model script has been developed for this purpose (refer to **Attachment 3**). You may continue to use existing scripts provided the information in the attached model document is conveyed during verification calls. Your script needs to be submitted to CMS through the normal process for approval.

Three documented attempts to contact the applicant by telephone within 10 calendar days of receiving the application are required. If you are unable to successfully complete the verification after the first attempt, you must send the applicant the model education letter (refer to **Attachment 4**). You must provide this letter in addition to any required enrollment notice, such as enrollment acknowledgement and confirmation letters (refer to **Attachments 5 and 6**, respectively). After the model education letter has been sent, you must make and document at least two additional attempts to successfully complete the verification. Be certain to document verification activities as they will be subject to compliance audit by CMS or its contractors.

Immediate implementation of this process is recommended; however, you must have this process in place before marketing CY 2008 PFFS plans.

6. PFFS Enrollment Processing

The special processes and marketing practices described in this memo are designed to ensure new enrollees have all required information to understand the plan in which they are enrolling. Conducting this outreach and education does not change the requirements to which all MA organizations must adhere for processing MA enrollment requests. Please refer to the CMS MA Eligibility, Enrollment and Disenrollment Guidance, available at www.cms.hhs.gov, for more information.

Best Practices

1. PFFS-specific sales presentation language

Model language is provided to incorporate into sales presentations describing the special aspects of PFFS plans which differ from supplements and other MA plans (refer to **Attachment 7**). You may submit this language with revised sales presentations using the normal marketing submission process.

2. Participation in HEDIS and HOS

We encourage organizations offering PFFS plans to participate in HEDIS and the Health Outcomes Survey (HOS) in 2008. Submitting this information helps CMS calculate and display much of the comparative information featured in the Medicare Options Compare tool. This tool is used by beneficiaries and their representatives in making informed health care decisions. You will receive more information regarding how to take advantage of this opportunity in the future.

3. Provider education plan

You are required to have staff available to assist providers with questions concerning plan payment and payment accuracy. Please refer to the document entitled "MA Payment Guide for Out of Network Payments" available on our web site at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats. In addition, we encourage PFFS plans to develop provider relations strategies to encourage a wide range of providers to accept PFFS enrollees. We suggest PFFS plans develop a provider education process and educational materials that includes establishing relationships with and educating providers in the PFFS plan service area.

To further assist providers, we have posted on the CMS website all the PFFS plans' contact information concerning PFFS plan terms and conditions of payment. Also, PFFS plans are required to make their terms and conditions of payment reasonably available to U.S. providers. A provider has reasonable access to a plan's terms and conditions of payment if the plan makes this information easily accessible through electronic mail, fax, telephone, or the plan website. The contact information for all PFFS contracts is posted on http://www.cms.hhs.gov/PrivateFeeforServicePlans/. Updates to the contact information will be made on a monthly basis.

New fields will be added in HPMS to allow PFFS plans to provide their plan terms and conditions of payment contact information for providers, which will be used to update the CMS website. CMS will inform all PFFS plans when the information may be entered in HPMS.

You should consider sending a provider educational material packet to those providers listed on enrollment requests (if provided), and those who call or bill for services that have not already received a packet. The contents of the provider education material packet could include the updated CMS provider education letter (refer to **Attachment 8**), the provider educational information in the document described above (refer to **Attachment 2**), and the terms and conditions of payment. We may require that organizations offering PFFS plans having documented provider access problems provide data about provider education and outreach efforts.

As stated in the 2008 Call Letter, CMS remains vigilant in protecting Medicare beneficiaries. We will focus compliance oversight activities on ensuring the provision of information to beneficiaries accurately represents the access, network, and payment features of PFFS plans generally, and each organization's specific plan. CMS has the authority to impose intermediate sanctions and penalties including the freezing of all marketing and enrollment, civil money penalties and other enforcement actions as described in Federal regulations at 42 C.F.R. §422 Subpart K and O, against organizations violating Medicare program requirements. We are closely monitoring beneficiary complaints and other marketplace-based information to determine whether compliance and/or enforcement actions are warranted.

We appreciate your cooperation in implementing these important steps. Please notify your Regional Office Plan Manager as you implement each of the items described above. You may direct any questions concerning these requirements to your Regional Office Plan Manager.

Attachment 1: *Group Sales Presentation Data Template*

PFFS Organization Name:

[illegible]

Date: mm/dd/yy	Time	Name of Brokerage Firm/ Agency/Sales Associate	Venue Name	Description of Venue (e.g., sales event at senior center, health fair)	Venue Phone Number	Venue Street Address	Venue City	Venue State	Venue Zip Code	Event Contact Person	Contact Phone Number	Contact e-mail Address
Example												
3/5/2007	1:00 AM	John Doe and Associates	Family Restaurant	PFFS product sales event	555-555-1212	123 Any Street	Any Town	MD	21244	John Doe	555-555-1111	jdoe@email.net

Attachment 2 – Side 1

What *People on Medicare* need to know about **Private Fee-for-Service plans**

<Plan name> is a Medicare Advantage private fee-for-service (PFFS) plan authorized by the Centers for Medicare & Medicaid Services (CMS). A PFFS plan is different than Original Medicare or an HMO, PPO, or Medicare supplement plan.

<Plan name> gives you the ability to choose your health care provider. However not all providers may accept this plan, even Medicare providers may not accept this plan. If you choose this plan, it is very important that all the providers you choose know, before providing services to you, that you have <plan name> coverage in place of Medicare. This gives your provider the right to choose whether or not to accept <plan name> terms and conditions of payment for treating you. Providers have the right to decide if they will accept <plan name> each time they see you. This is why you must show your <plan name> ID card every time you visit a health care provider.

If your provider agrees to <plan name> terms and conditions of payment
If your provider decides to accept the <plan name> plan, they must follow our plan's terms and conditions for payment. They must thereafter bill <plan name> for those services. However, providers have the right to decide if they will accept <plan name> each time they see you.

[*Include if plan uses a network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.*] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]]

If your provider does not agree to <plan name> terms and conditions of payment
A provider may decide not to accept <plan name>'s terms and conditions of payment. If this happens, you will need to find another provider that will. You may contact us at <phone number> for assistance locating another provider in your area willing to accept our plan's terms and conditions of payment.

What happens if a provider declines to accept <plan name>'s terms and conditions of payment?

1. They should not provide services to you except for emergencies.

2. If they choose to provide services, they may not bill you. They must bill <plan name> for your covered health care services. You must pay the appropriate copays or coinsurance at the time of service.

For more information about PFFS plans see Beneficiary Qs & As at CMS's web site http://www.cms.hhs.gov/PrivateFeeforServicePlans/. If you have questions about <plan name>, please call our <customer service> department at <phone number>.

[Optional: plan logo and tagline]

Attachment 2 – Side 2

What *Health Care Providers* need to know about **Private Fee-for-Service plans**

<Plan name> is a Medicare Advantage private fee-for-service (PFFS) plan authorized by the Centers for Medicare & Medicaid Services (CMS). A PFFS plan is different than an an HMO, PPO, or Medicare supplement plan.

A beneficiary who enrolls in a Medicare Advantage PFFS plan is free to use any provider willing to treat the enrollee and accept our plan's terms and conditions of payment. You can view our terms and conditions of payment by visiting our website at <plan website>, and if you have questions, then you can call us at <phone number>. Enrollees must inform you, before obtaining services from you, that they have purchased <plan name> for their Medicare coverage. This gives you the right to choose to accept <plan name> enrollees. You have a right to make that choice each time service is needed by a <plan name> enrollee. You do not have to sign a contract to see <plan name> enrollees.

[*Include if plan uses network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept the plan's terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract*] Enrollees of <plan name> can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept the plan's terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]]

If you decide to accept <plan name> terms and conditions of payment
Your agreement to our plan's terms and conditions of payment is inherent in your decision to treat a <plan name> enrollee. If you decide to treat a <plan name> enrollee, you will be subject to our plan's terms and conditions of payment and must bill <plan name> for covered services. However, you have the right to decide, on a patient-by-patient and visit-by-visit basis, whether to treat <plan name> enrollees. You may learn our terms and conditions of payment and other information about our plan <on our website at _____/by calling us at _____>. [Optional: insert brief description of payment rates, enrollee cost sharing, or other aspects of the plan's terms and conditions of payment.]

If you decide not to accept <plan name> terms and conditions of payment
If you decide not to treat a <plan name> enrollee, you should not provide services to the enrollee, except for emergencies.

If you choose to provide services, then you have by default agreed to our terms and conditions of payment and you must bill <plan name> for covered health care

services. You must collect from the enrollee only the appropriate <plan name> copays or coinsurance at the time of service. You may at any time, on a patient-by-patient and visit-by-visit basis, decide that you do not want to treat a <plan name> enrollee.

We will follow CMS requirements for timely payment of claims. [Optional: provide average claims payment timeframe, such as, "Our average payment timeframe during <year> was <____ days>."] You may learn our billing requirements <on our website at _____/by calling us at _____>.

For more information about PFFS plans see Provider Qs & As at CMS's web site http://www.cms.hhs.gov/PrivateFeeforServicePlans/. If you have questions about <plan name>, please call our <provider relations> department at <phone number>.

[Optional: plan logo and tagline]

Attachment 3: Model PFFS Education and Verification Script

[Greeting:]
Hello, my name is <caller's first name>, and I am calling from <MA Organization or plan name>. We have recently received your request to enroll in <plan name>, a Medicare Advantage Private Fee-for-Service Plan. This call is to make sure that you understand how a Private Fee-for-Service Plan works and to answer any questions that you have. You don't have to provide any information to me, and any information you do provide will in no way affect your ability to join our plan. This should take about XX minutes. May we continue? [*If applicable*: This call may be monitored or recorded]

[If yes, proceed to [Introduction to Plan Rules:] below.]

[If no:] Alright, <Mr./Ms.><beneficiary name>. Is there a better time when I should call again?

[If yes, take down date and time to call and proceed to close.]

[If no:] Thank you for choosing <MAO name/plan name>. We will be sending you letters about your enrollment request soon. **[End call.]**

[Introduction to Plan Rules:]
Thank you, <Mr./Ms.> <applicant name>. In order to make sure you understand how the plan works, I will review some important information about getting care as member of <Name of Plan>.

[PFFS plan rules:]

- <Plan name> is a Medicare Private Fee-For-Service plan and not a Medicare supplement, Medigap, or Medicare Select plan. This means that <plan name> pays ***instead*** of Medicare. You will pay the cost sharing listed in <plan's name> the summary of benefits provided with the application.
- Once enrolled, you can not use your red, white and blue Medicare card to get healthcare, because the Original Medicare Plan won't pay for your healthcare while you are enrolled in this plan. You should keep your Medicare card in a safe place in case you return to the Original Medicare Plan in the future.

- You may get health care services from any provider allowed to bill Medicare and who agrees to accept our payment terms and conditions.
- It is important that all of your health care providers be made aware, before you get any services, that you have joined <plan name>, which is a PFFS plan. This gives your provider the right to choose whether to accept our plan's payment terms and conditions. The provider can make a different choice to accept the terms and conditions of payment each time you need service. This is why you must show your <plan name> ID card every time you visit a health care provider. It is important to understand that Medicare providers and suppliers are not obligated to treat Medicare beneficiaries enrolled in PFFS plans, though they can choose to do so. There is a <phone number and/or website> on your <Plan name> ID card for the provider to find out about the terms and conditions of payment.
- If your provider decides to accept the payment terms of the <plan name> plan, he or she must bill <plan name> for those services. However, each provider has the right to decide whether or not they will accept <plan name> each time they see you.
- If your provider decides not to accept the payment terms of the <plan name> plan, you will need to find another provider that will. They should not provide services to you, except in an emergency.
- [***Include if plan uses a network of contracted providers:*** <Plan name> has direct contracts with some providers who have already agreed to accept our plan's terms and conditions of payment. [Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.] You can still get care from other providers who do not contract with us as long as they agree to accept our plan's terms and conditions of payment. [Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.]]
- [*Use if applicable:* You must use network pharmacies to obtain prescription drugs, except in emergencies or urgent situations.]
- [***Include if plan offers Part D:*** *If you have limited income and resources,* you may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048,

24 hours a day, 7 days a week. Or, call the Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778. You may also call your State Medicaid Office.]

<Mr./Ms> <applicant name>, do you understand what I have just explained to you?

[If yes, continue to [Enrollment cancellation policy] below.]

[If no: you must ask the applicant about any specific questions they have, and answer those questions. You may need to explain the information above again until the applicant understands.]

[Enrollment cancellation policy]

If you have any questions or would like to cancel the processing of your enrollment, please call our Member Services Department at <phone number>. You must notify us of your intent to cancel the processing of your enrollment within 7 calendar days after receiving this phone call or by <last day of the month in which the request for enrollment was received>, whichever is later. TTY users should call <*TTY* number>. We are open <insert days/hours of operation and, if different, *TTY* hours of operation>.

[Close:]

- <Mr./Ms.> <applicant name>, it was a pleasure speaking with you today. We will soon send you a letter telling you we received your completed enrollment form. [*Use if plan uses enrollment acknowledgement letter as temporary proof of coverage:* You should use this letter as a temporary <plan name> ID card before you get health care.] We will also send you a member ID card soon. Once you get it, remember to show your ID card to your doctor or hospital before you get healthcare. Thank you for your time and for choosing <plan name> as your health plan. **[End call.]**

Attachment 4: Model Letter to Beneficiaries Who Could Not be Reached for Verification by Phone

[Member # - if member # is SSN, only use last 4 digits]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <Name of Member>:

We have received your request to enroll in <plan name>, a Medicare Advantage Private Fee-for-Service Plan. We are sending you this letter to make sure that you understand how a Private Fee-for-Service Plan works. We also tried to contact you by telephone, but were unable to reach you.

Please review some important information below to make sure you understand how our plan works and how you can get care as a member of <plan name>. You should also share this letter with someone who helps you make important decisions such as your spouse, children, trusted friends, or your physician.

- <Plan name> is a Medicare Private Fee-for-service plan and not a Medicare supplement, Medigap, or Medicare Select plan. This means that <plan name> pays for your healthcare services ***instead*** of Medicare. You will pay the cost sharing listed in <plan name's> Summary of Benefits (or Evidence of Coverage) provided with the application.

- Once enrolled, you can not use your red, white and blue Medicare card to get healthcare, because the Original Medicare Plan won't pay for your healthcare while you are enrolled in this plan. You should keep your Medicare card in a safe place in case you return to the Original Medicare Plan in the future.

- You may get health care services from any provider allowed to bill Medicare **and** who agrees to accept our payment terms and conditions before treating you (except in an emergency).

- It is important that all of your health care providers are aware, **before** you get any services, that you have joined <plan name>. This gives your provider the right to choose whether to accept our plan's payment terms and conditions. The provider can make a different choice to accept the terms and conditions of payment each time you need service. This is why you must show your <plan name> ID card every time you visit a health care provider. There is a <phone number and/or website> on your <Plan name> ID card for the provider to find out about the terms and conditions of payment. You may use the leaflet we gave you to help your provider understand this plan.

- If your provider decides to accept the payment terms of <plan name>, he or she must bill <plan name> for those services.

- If your provider decides not to accept the payment terms of <plan name>, you will need to find another provider that will. They should not provide services to you, except in an emergency.

- [***Include if plan uses a network of contracted providers:*** <Plan name> has direct contracts with some providers who have already agreed to accept our plan's terms and conditions of payment. [Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.] You can still get care from other providers who do not contract with us as long as they agree to accept our plan's terms and conditions of payment. [Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.]]

- [***Use if applicable:*** You must use network pharmacies to obtain prescription drugs, except in emergencies or urgent situations.]

- [***Include if plan offers Part D:*** *If you have limited income and resources,* you may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day, 7 days a week. Or, call the Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778. You may also call your State Medicaid Office.]

We will soon send you a letter telling you we received your completed enrollment form. [*Use if plan uses enrollment acknowledgement letter as temporary proof of coverage:* You should use this letter as a temporary <plan name> ID card before you get health care.] We will also send you a member ID card soon. Once you get it, remember to show your member ID card to your doctor or hospital before you get healthcare.

If you have any questions or would like to cancel the processing of your enrollment, please call our Member Services Department at <phone number>. You must notify us of your intent to cancel the processing of your enrollment within 7 calendar days after receiving this letter or by <last day of the month in which the request was received>, whichever is later. TTY users should call <*TTY* number>. We are open <insert days/hours of operation and, if different, *TTY* hours of operation>. Thank you for choosing <plan name> as your health plan.

Attachment 5: Model Notice to Acknowledge Receipt of Completed PFFS Enrollment Election

Referenced in section(s): 40.4.1, 60.4

[Member # - if member # is SSN, only use last 4 digits]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Beginning <effective date>, you will begin to get your healthcare from <plan>. You must show your <Plan name> ID card to your doctor or hospital before you get healthcare. You can not use your red, white and blue Medicare card to get healthcare, because **Original Medicare will not pay for your healthcare while you are enrolled in this plan.** You should keep your Medicare card in a safe place.

<Plan name> allows you to go to any Medicare-approved doctor or hospital **if** they agree to accept the plan's payment terms before treating you, as provided in your [*insert either "Member handbook" or enrollment materials*]. Not all providers accept the plan's payment terms. You should contact your doctor to ask whether he or she will accept our plan's payment terms. There is a phone number or website on "your <Plan name> ID card" for the provider to find out about the terms and conditions of payment. If your doctor does not accept our plan's payment terms, you will not be able to obtain healthcare services from this doctor while you are enrolled in our plan (except in emergencies). You may contact us at the number at the end of this letter for assistance locating another provider in your area willing to accept the plan's payment terms.

You will need to pay your plan co-payments and co-insurance at the time you get healthcare services, as provided in your member materials. If any doctor provides healthcare to you after learning about our plan's payment terms, they must bill us for services, and are not allowed to send the entire bill to you.

[***Include if plan uses a network of contracted providers:*** <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.*] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]]

[***Optional language:*** This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.]

Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <Plan>. But you should not wait to get this letter before you begin showing your <Plan> ID card (or this letter) to your doctors on <effective date>. Also, do not cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the confirmation letter.

[*Plans without Part D do not use this paragraph and plans without a premium do not use the following two paragraphs:* If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. We will bill you for the portion of your monthly premium that you owe. You can pay by mail or by electronic Funds Transfer (EFT). [*Optional – insert other billing interval options, if available].*

If you choose, you can have your monthly premium automatically deducted from your Social Security check. Generally you must stay with the option you choose for the rest of the year. If you are interested in this option, please contact us at <plan telephone number>. TTY users should call <TTY number>.]

You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you do not have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <Plan> will pay for those services. Also, if you have end stage renal disease (ESRD), you may not be able to be a member of <Plan>, and we may have to send you a bill for any health care you've received.

Once enrolled in our plan, you can only make changes during certain times of the year. Between January and March, you have an opportunity to make one change, but you can only join a plan [*plans with drug benefit:* that has prescription drug coverage] [*plans without a drug benefit:* that does not have prescription drug coverage]. Between November 15th and December 31st each year, anyone can make any type of change. If you have more questions about this, please feel free to call our member services department.

If you have any questions, please call our Member Services Department at <phone number>. TTY users should call <*TTY* number>. We are open {insert days/hours of operation and, if different, *TTY* hours of operation}. Thank you.

Attachment 6: Model Notice to Confirm PFFS Enrollment

Referenced in section: 40.4.2

[Member # - if member # is SSN, use only last 4 digits]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Medicare has approved your enrollment in <MA Plan> beginning <effective date>. Beginning <effective date>, you will begin to get your healthcare from <plan>. You must show your <Plan name> ID card to your doctor or hospital before you get healthcare. You can not use your red, white, and blue Medicare card to get healthcare, because **Original Medicare will not pay for your healthcare while you are enrolled in this plan.** You should keep your Medicare card in a safe place. [*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.]

As we told you before, <Plan name> allows you to go to any Medicare-approved doctor or hospital that agrees to accept our plan's payment before treating you, as provided in your [*insert either "Member handbook" or "Evidence of Coverage"*]. You should contact your doctor to ask whether he or she will accept our plan's payment terms. There is a phone number or website on "your <Plan name> ID card" for the provider to find out about the terms and conditions of payment. If your doctor decides not to accept our plan's payment terms, except for emergencies, you will not be able to get healthcare services from this doctor while you are enrolled in this plan. You may contact us at the number at the end of this letter for assistance locating another provider in your area. If any doctor provides healthcare to you after learning about our plan's payment terms, they must bill us for services, and are not allowed to send the entire bill to you. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials.

[*Include if plan uses a network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.*] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]]

[*MA-PD insert the following if no low-income subsidy:* The monthly premium for your plan is [insert premium].

[MA-PD, if low-income subsidy applicable: Because you qualify for extra help with your prescription drug costs, you will pay:

- A monthly premium of [insert premium less amount of premium assistance for which the individual is eligible],
- [insert appropriate LIS deductible amount] for your yearly prescription drug plan deductible,
- [insert appropriate LIS copay amount] copayment when you fill a prescription.]

[*Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance*]

[*Insert the following if LEP applies:* Of the <insert premium> monthly premium amount, <LEP amount> is late enrollment penalty, due to Medicare not being able to confirm that you were enrolled in Medicare prescription drug coverage or other creditable prescription drug coverage for <# of uncovered months> months since the end of your Medicare Part D Initial Enrollment Period. <Plan name> can tell you how the late enrollment penalty is calculated and how we reviewed any creditable coverage evidence you submitted.]

[Insert the following ONLY if LEP applies and EGWP plan sponsor is paying the LEP amount on behalf of the individual: <name of employer or union sponsoring the plan> has agreed to pay the LEP amount on your behalf. You need to know that if your coverage is terminated by <name of employer or union sponsoring the plan>, you will be solely responsible for paying this LEP amount if and when you join another Medicare drug plan.]

[*Insert the following if LEP applies*: **If you believe your late enrollment penalty is incorrect,** call <plan name> at <plan telephone number> to find out how you can ask for a reconsideration (review) of the late enrollment penalty. Your reconsideration request must be filed by <date of this letter + 60 days>. **Keep a copy of this letter.** If you ask for a reconsideration of the late enrollment penalty decision, you will need to include a copy of this letter with your request.]

Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. (Please note that if this is the first time that you are a member of a Medicare Health Plan (Medicare Advantage or Medicare Cost plan), you may have a trial period during which you have certain rights to *leave (*disenroll from*)* <MA Plan> and purchase a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) for further information about Medigap policies. TTY users should call 1-877-486-2048.

If you have any questions, please call our Member Services Department at <phone number>. TTY users should call <*TTY* number>. We are open {insert days/hours of operation and, if different, *TTY* hours of operation}. Please be sure to keep a copy of this letter for your records. Thank you.

Attachment 7

Model Language for Sales Presentation

<Plan name>

Medicare Advantage

Private Fee-For-Service Plan

What is a Private Fee-for-service plan?

- It is a type of Medicare Advantage plan offered by a private insurance company like <MA Organization>
- It is ***not*** the same as the Original Medicare plan that is offered by the Federal Government
- It is ***not*** a Medicare supplement, Medigap, Medicare Select, or Prescription Drug Plan

How does a Private Fee-for-service plan work?

- The Private Fee-for-service plan pays ***instead*** of Medicare. You will pay amounts that the Private Fee-for-service plan does not pay, which are called copayments and coinsurance. A Private Fee-for-service plan does ***not*** pay after Medicare pays its share.
- Original Medicare will not pay for your health care while you are enrolled in a Private Fee-for-service plan.

How do you obtain services from a Private Fee-for-service plan?

- You may receive health care services from any provider allowed to bill Medicare who **agrees** to accept the Private Fee-for-service plan's payment terms and conditions.
- [Use if applicable: You must use network pharmacies to obtain prescription drugs, except in emergencies or urgent situations.]

Before seeing a provider you should ...

- Verify that your provider will accept the <plan name> plan. Your health care providers have the right to choose whether to accept a Private Fee-for-service plan's payment terms and conditions every time you see your providers.
- If your provider decides not to accept the plan, you will need to find another provider that will.
    - They should not provide services to you, except in an emergency.
    - If they choose to provide services, they may not bill you. They must bill the Private Fee-for-service plan for your covered health care services. You must pay the appropriate copayments and coinsurance.

- [*Include if plan uses a network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept the plan's terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.*] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept the plan's terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]]

When you go to the doctor or hospital, ...

- Show your <plan name> ID card and tell them that you have chosen <plan name> for your Medicare health plan.
- Do not show your red, white and blue Medicare card.
- Pay any <plan name> copayments or coinsurance at the time of service.

The doctor or hospital will bill <plan name> for the rest.

- Health care providers must bill the Private Fee-for-service plan.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244

This letter is intended to inform providers of a new option, not to endorse
<name of plan>

Dear Provider:

In the Centers for Medicare & Medicaid Services' (CMS) continuing mission to improve access to health care for the [44] million Medicare beneficiaries nationwide, we have worked with various organizations that have expressed an intent to contract with CMS as Medicare Advantage (MA) Organizations, and to offer MA plans to Medicare beneficiaries. Historically, all MA plans offered to beneficiaries were "managed care" products, under which beneficiaries who enrolled were limited, at least to some extent, to a specified network of providers.

On <date>, <organization name> received authorization from CMS to offer an MA "private fee-for-service" (PFFS) plan, under which a beneficiary who enrolls is free to seek services from any provider who is willing to accept the plan's terms & conditions of payment and treat the enrollee. Because this type of MA plan is new to many providers, the following information is furnished concerning some of the special features of a MA PFFS plan.

[*Include the following if you have no signed contracts with any providers:*
In order to offer a PFFS plan without entering into signed contracts with a sufficient number of providers to meet MA access standards, the MA Organization must agree to pay all Medicare eligible providers at least the current Medicare Allowable rates (including original Medicare deductibles and coinsurance) minus any MA plan specific enrollee cost sharing. This minimum payment rate for non-network PFFS plans is mandated via regulation (42 CFR 422.114) as well as the contract that CMS holds with an MA Organization. (For details on provider eligibility see Provider Q & A #1 on CMS's web site at http://www.cms.hhs.gov/privatefeeforserviceplans.)]

If a PFFS plan establishes payment rates for any category of providers (e.g., physicians, hospitals, etc.) in its terms & conditions of payment that are less than original Medicare payment rates, it then must have that category or categories of providers under direct signed contract. The reason for this requirement is that if a PFFS plan establishes a payment rate that is less than that of original Medicare, the plan will need to have direct contracting providers to ensure that its enrollees can go to those providers to receive services. While enrollees in PFFS plans can always seek care from any eligible provider in the U.S. who is willing to accept the plan's terms & conditions of payment, if the plan's payment rate is less than original Medicare, many providers may decline to treat the enrollees.

[*Include the following if you have signed contracts with some, but not all, categories of providers:* <Plan name> has established a PFFS model where we pay some category of providers at least the original Medicare rate and for certain other categories of providers we pay less than the original Medicare rate. [List provider types paid less than original Medicare]

The PFFS payment rules for providers are mandated via regulation (42 CFR 422.114 and 422.216) as well as the contract that CMS holds with an MA Organization. (For details on provider eligibility see Provider Q & A #1 on CMS's web site at http://www.cms.hhs.gov/privatefeeforserviceplans.)]

Providers are prohibited from balance billing enrollees of the PFFS plan unless the PFFS plan allows the provider to do so in its terms & conditions of payment. PFFS plans have the option of allowing providers to balance bill members up to 15% of the plan payment rate (42 CFR 422.216 (b)). Other than any plan allowed "balance billing" amount, providers must bill only for copayments, deductibles or coinsurance described in the MA Organization's terms and conditions of payment. Providers must always abide by the PFFS plans terms & conditions of payment for any services he or she chooses to furnish to PFFS enrollees.

Other important aspects of PFFS plans include:

- If a provider decides to accept the PFFS plan, they must follow the PFFS plan terms and conditions of payment. Provider agreement to the plan terms and conditions of payment is inherent in their decision to treat a PFFS plan enrollee. If a provider decides to treat a PFFS plan enrollee, then the provider must bill the PFFS plan for covered services. The provider has the right to decide, on a patient-by-patient and visit-by-visit basis, whether to treat PFFS plan enrollees. If a provider decides not to accept the PFFS plan terms and conditions of payment, then the provider should not provide services to the PFFS plan enrollees, except in an emergency.

- CMS audits the MA Organization to ensure that it pays providers the appropriate amount for services furnished to plan enrollees and that it pays clean claims within 30 days.

- An authorized MA Organization that offers a PFFS plan is subject to the same financial solvency requirement as any other MA Organization approved by CMS.

- Payments made by an MA Organization that offers a PFFS plan cannot place providers at risk by using such reimbursement methods as capitation or withholds; and correspondingly, cannot base payment on the organization's performance using bonuses or incentives.

- Any advertising, marketing collateral or marketing practice must be filed with CMS prior to their use.

- An organization that wants to offer a PFFS plan is required to seek and receive acknowledgement and approval from every State Department of Insurance prior to offering a PFFS plan. [note this does not apply to certain employer only PFFS plans which have used the EPOG state licensing waiver.]

We recognize that as with any new plan, there can be confusion both from the provider and beneficiary communities. We continue to work with <organization name> to make sure all parties involved have sufficient information when deciding whether to accept the <plan name> plan or any Medicare Advantage program available to them in the area. Additional information, including questions and answers addressing frequently asked beneficiary and provider questions can be found on CMS's web site at http://www.cms.hhs.gov/privatefeeforserviceplans/, as well as the <plan name> web site at <plan web site>.

Sincerely,

David A. Lewis
Director
Medicare Advantage Group